

## 2005 RYAN WHITE RECORD REVIEW OF PSYCHOLOGICAL SERVICES

Provider: AUTO FILL

CIS Number: AUTO FILL

Agency Identification Number: AUTO FILL

Gender: AUTO FILL

Race Ethnicity: AUTO FILL

Date of Review:

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Signature of Reviewer:

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Date of Intake:

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Date of Last Service (Case Note):

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### Intake: Required Forms

- |  |                              |   |
|--|------------------------------|---|
| 1. Informed consent for treatment signed by the client?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |
| 2. Confidentiality statement signed by client?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |
| 3. A signed consent to exchange and release information in client's file?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |
| 4. Grievance procedures, client's rights and responsibilities explained and documented?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |
| 5. Is there a Ryan White Certified Referral form in the chart?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |
| 6. If there is no Ryan White Certified Referral in the chart, is there a Ryan White Title I composite consent for enrollment?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA |
| 7. If there is no Ryan White Certified Referral in the chart is there documentation of financial eligibility in clients file?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA |
| 8. If there is no Ryan White Certified Referral in the chart is there documentation and Proof of HIV status in client's file?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA |
| 9. If there is no Ryan White Certified Referral in the chart is there documentation of screening for Medicaid or other funding source for psychosocial and/or pastoral care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA |
| 10. Documentation that choice of treatment was offered?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |
| 11. Documentation of a psychosocial assessment completed within one month of presenting for services?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                             |

### Intake: Clinical History and Assessment

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 12. Initial Sociodemographic data (age, race/ethnicity, gender, etc.) collected and documented? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

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13. Is there documentation of presenting (at intake) mental status and symptoms? ☐ Yes ☐ No
14. Is there documentation of current mental status and symptoms? ☐ Yes ☐ No
15. Is there documentation of mental health history? ☐ Yes ☐ No
16. Is there documentation of current psychotropic medications being prescribed? ☐ Yes ☐ No ☐ NA
17. Is there documentation of current medical issues/ problems? ☐ Yes ☐ No ☐ NA
18. Is there documentation regarding Family/Social Support? ☐ Yes ☐ No
19. Is there documentation regarding Financial Issues? ☐ Yes ☐ No
20. Is there documentation regarding Educational background? ☐ Yes ☐ No
21. Is there documentation regarding Occupational Status? ☐ Yes ☐ No
22. Is there documentation regarding an assessment of past history of physical or sexual abuse or neglect? ☐ Yes ☐ No
23. Is there documentation of an assessment of housing status or issues? ☐ Yes ☐ No
24. Is there documentation of an assessment for substance abuse? ☐ Yes ☐ No
25. Client's reason for seeking care documented? ☐ Yes ☐ No

**Clinical Documentation**

26. Is there a thorough assessment of dangerousness (suicidal ideation/homicidal ideation)? ☐ Yes ☐ No
27. Is there an assessment for severe and acute psychological symptoms (hallucinations/paranoid ideation/delusions)? ☐ Yes ☐ No
28. Is there a complete Multi-axis Diagnosis based on DSM IV TR criteria? ☐ Yes ☐ No
29. Issues that may affect the provision of treatment explored with client? (faith group, gender, culture, sexual orientation, language, access to service including time of operation, etc.) - ☐ Yes ☐ No
30. Referrals to treatment made if substance abuse problems were identified or suspected? ☐ Yes ☐ No ☐ NA
31. If substance abuse behaviors are documented is there an assessment of frequency of use and duration of use? ☐ Yes ☐ No ☐ NA

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32. Referral for psychiatric evaluation made if problem identified or suspected? ☐ Yes ☐ No ☐ NA
33. Was there a referral for a crisis evaluation made if appropriate or necessary? ☐ Yes ☐ No ☐ NA

**Clinical Documentation Regarding HIV / AIDS Issues**

34. Is there documentation indicating that client risk related behaviors were assessed? ☐ Yes ☐ No
35. Was education provided on safer sex, condom use, not sharing needles, etc.? ☐ Yes ☐ No
36. Was adherence to treatment and medications discussed? ☐ Yes ☐ No
37. Is Permanency planning discussed? ☐ Yes ☐ No

**Treatment & Treatment Documentation**

38. Is there a discussion of the condition being treated? ☐ Yes ☐ No
39. Is there a current treatment (less than 2 months) plan in client's charts? ☐ Yes ☐ No
40. If there is no current treatment plan in the chart is there an initial available treatment plan? ☐ Yes ☐ No ☐ NA
41. Is the available or current treatment plan signed by the client? ☐ Yes ☐ No ☐ NA
42. Is the available or current treatment plan signed by the counselor/therapist? ☐ Yes ☐ No ☐ NA
43. Is the available or current treatment plan dated? ☐ Yes ☐ No ☐ NA
44. Do the treatment plans address identified problems? ☐ Yes ☐ No ☐ NA
45. Does the treatment plan fit with the issues identified in the initial client assessment? ☐ Yes ☐ No ☐ NA
46. Do the treatment plans contain client treatment goals? ☐ Yes ☐ No ☐ NA
47. Are these goals measurable? ☐ Yes ☐ No ☐ NA
48. Do the treatment plans include target dates for achieving goals? ☐ Yes ☐ No ☐ NA
49. Is there documentation of whether there is progress ( or lack of) toward meeting goals? ☐ Yes ☐ No ☐ NA
50. Are the treatment plans reviewed monthly with the client? ☐ Yes ☐ No ☐ NA

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51. Is the type of service (group or individual) documented? ☐ Yes ☐ No
52. Is the recommended frequency of services documented? ☐ Yes ☐ No
53. Is there a clear justification for treatment? ☐ Yes ☐ No
54. Are there progress notes in the chart? ☐ Yes ☐ No
55. Do the progress notes and or treatment plan document improvement, decompensation or maintenance of client's condition or situation? ☐ Yes ☐ No
56. Does the treatment intervention seem adequate or justified for the client's condition / mental status? ☐ Yes ☐ No
- If No, Explain:

57. Does the provider address non-compliance to treatment if appropriate? ☐ Yes ☐ No ☐ NA

**Discharge or Case Closing**

58. Are there gaps in treatment?  
If yes how long is the gap in treatment \_\_\_\_\_ ☐ Yes ☐ No
59. If the client stopped treatment without a formal closing of the case, is there evidence that follow-up was attempted? Mark NA if client is still in treatment ☐ Yes ☐ No ☐ NA
60. Has this case been closed / client discharged? If the case is still open mark NA for questions 61- 65 ☐ Yes ☐ No ☐ NA
61. Is there a reason for closing case documented? ☐ Yes ☐ No ☐ NA
62. Final contact completed and dated in chart? ☐ Yes ☐ No ☐ NA
63. Is there documentation that treatment was successfully completed (goals were met)? ☐ Yes ☐ No ☐ NA
64. Was the client referred or transferred to another treatment agency? ☐ Yes ☐ No ☐ NA

**Credentialing Requirements**

65. Are the credentials of the person providing services clearly documented in the progress notes? ☐ Yes ☐ No ☐ NA
66. Is the provider of services appropriately qualified to treat the client's issues or problems? ☐ Yes ☐ No

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67. Documentation of supervision of non-licensed paraprofessional counselor/therapist by a licensed professional?

☐ Yes

☐ No

☐ NA

**Other:**

68. In this chart what level services were provided primarily? Please indicate the level:

☐ L1

☐ L2

☐ L3

☐ L4

69. If there is an available Axis I Diagnosis; please indicate what it is:

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**Comments:**

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